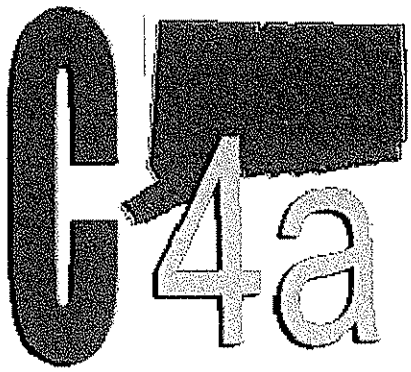

Connecticut Association of Area Agencies on Aging, Inc.

Testimony – Appropriations Committee 3/11/10

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Positions

➢ **Governor's March 1, 2010 Deficit Mitigation Plan for SFY'10**

C4A **opposes** various of the Governor's proposals to reduce appropriations for core, preventative home and community-based long-term care services that permit older adults and individuals with disabilities to live independently in the community and that achieve dramatic cost savings to the State in preventing institutionalization. These proposed cuts will compromise:

- access to core, community-based long-term care services;
- utilization of essential programs of support; and
- capacity of the long-term care network.

Cuts that Will Compromise *Access* to Core, Community-Based Long-Term Care Services

➢ C4A **opposes** the Governor's proposal to eliminate Medicaid coverage for non-emergency dental and eyeglasses.

For older adults and people with disabilities, preventative dental services help to forestall acute health conditions (e.g. heart disease) and to ensure adequate nutrition. Eyeglasses are an essential support for safe mobility and accurate use of prescription drugs.

Cuts that Will Compromise *Utilization* of Essential Programs of Support

➢ C4A **opposes** the proposal to further restrict state prescription drug "wrap-around" protection for enrollees of Medicare Part D by imposing additional cost sharing obligations on individuals who are already obligated to pay up to $15 per month in co-payments.

In the 2009 session, the Legislature significantly retracted "wrap-around" coverage by:

- requiring participants to pay up to $15 in co-payments per month;
- limiting state support to Medicare D plans whose cost is equal to or lesser than the cost of a "benchmark" plan; and
- drastically limiting state funded coverage of non-formulary drugs.

Older adults and individuals with disabilities who are surviving on fixed income budgets cannot bear additional cost sharing.

➢ C4A also **opposes** the proposal to impose cost-sharing on low-income participants of the Medicaid program.

As a frame of reference, an individual applying for "community" Medicaid in most parts of Connecticut must show a monthly income of less than $506.22 per month ($672.10 for a couple). Given their low incomes, Medicaid recipients do not have sufficient income or savings through which they can bear cost-sharing for the services that they receive. Already burdened with significant out-of-pocket expenses, including over-the-counter medical supplies, utilities and food, recipients erode what little they have to live on each time a co-payment is made.

➢ Further, C4A **opposes** the proposal to adopt a more restrictive definition of medical necessity for purposes of Medicaid coverage determinations.

The current definition requires "maintenance of an optimal level of health", and the revised definition would be much more restrictive in limiting coverage to "reasonable and necessary" or "appropriate" services.

Cuts that Will Compromise the *Capacity* of the Provider Network

- C4A **opposes** the Governor's proposal to reduce by 5% certain Medicaid reimbursement rates to long-term care providers, and to rescind rate increases for adult day care providers.

Data from professional groups including the Connecticut Home Care Association and the Connecticut Association for Adult Day Care indicate that Medicaid reimbursement rates to providers of home and community-based services have not kept pace with increased costs of doing business (e.g. staff recruitment and retention, insurance and quality assurance/ regulatory compliance efforts). Inadequacy of reimbursement has directly contributed to closure of many home care agencies and adult day care centers over the

last five years, just when expansion of the available service array is most needed by both older adults and individuals with disabilities.

Background

Prescription Drug Coverage

Connecticut should affirm its long-time commitment to older adults, individuals with disabilities and other low-income people by resisting proposals to make further cuts in Connecticut's "wrap-around" coverage to the Medicare Part D prescription drug benefit; notably, imposition of additional cost-sharing requirements on those least able to bear these costs.

For participants of ConnPACE, the State has in the past several years covered Medicare Part D monthly premiums, formulary drugs needed during the "gap" period under the federal coverage, and most prescription drug costs (co-payments and deductible requirements) over the standard $16.25 co-payment. Additionally, the Legislature provided those who are dually-eligible for Medicare and Medicaid with coverage of the $1-$5 co-payments that they would otherwise have been obligated to pay. Finally, for both ConnPACE and Medicaid recipients, the Legislature in 2006 appropriated $5 million to provide initial coverage for non-formulary drugs.

In the 2009 session, the Legislature significantly retracted "wrap-around" coverage by:

- requiring participants to pay up to $15 in co-payments per month;
- limiting state support to Medicare D plans whose cost is equal to or lesser than the cost of a "benchmark" plan; and
- drastically limiting state funded coverage of non-formulary drugs.

Older adults and individuals with disabilities who are surviving on fixed income budgets cannot bear additional cost sharing. As a frame of reference, an individual applying for "community" Medicaid in most parts of Connecticut must show a monthly income of less than $506.22 per month ($672.10 for a couple). Given their low incomes, Medicaid recipients do not have sufficient income or savings through which they can bear cost-sharing for the services that they receive. Already burdened with significant out-of-pocket expenses, including over-the-counter medical supplies, utilities and food, recipients erode what little they have to live on each time a co-payment is made. The Legislature should reaffirm its commitment to protecting this population from increased co-payments, which leave those affected exposed to unacceptable barriers to accessing drugs that are desperately needed to enable them to remain safe and stable in the community.

Over and above issues of cost, full coverage of needed drugs is also a critical issue. Due to frailty and compromised health status, this population is heavily dependent on pharmacy coverage. Older Medicaid recipients are predominantly female, widowed and likely to live at home alone. Recipients evidence high incidence of chronic health conditions including congestive heart failure, hypertension, and diabetes that necessitate an evolving array of complementary medications. A significant incidence of clients must also contend with the debilitating effects of Alzheimer's or other dementia. Younger individuals with disabilities face parallel financial and physical constraints as they also

subsist on fixed income budgets and require multiple medications to remain physically and psychiatrically stable. For all of these reasons, the proposal to impose prior authorization requirements on all mental health drugs is of great concern.